MAXIMUS Federal Services

Case Number:	CM15-0102430		
Date Assigned:	06/04/2015	Date of Injury:	02/18/2013
Decision Date:	07/10/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/28/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Emergency Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 54 year old male with an industrial injury dated 02/18/2013. His diagnoses included failed neck surgery syndrome, cervical degenerative disc disease at cervical 3-4, cervical radiculopathy and left shoulder pain with impingement issue and rotator cuff problem. Past surgical history included cervical 5-6 and cervical 6-7 anterior fusion with instrumentation 08/06/2013 and left shoulder arthroscopy 02/11/2014. Prior treatment included diagnostics (x-rays, CT cervical spine, MRI of cervical spine and MRI of left shoulder. Co morbid diagnosis was hypertension. She lists sensitivity to non-steroidal anti-inflammatory drugs. He presented on 03/27/2015 with complaints of chronic and aching neck and left upper extremity pain with numbness and tingling of the left hand and headaches. He stated medications reduce pain by 10-30%. He reports that the benefit of chronic pain medication maintenance regimen, activity restriction and rest continue to keep pain within a manageable level to allow the injured worker to complete necessary activities of daily living such as walking, shopping and light household chores. He reports the pain affects his mood, sleeping patterns, work and overall functioning. His current medications included Percocet, Allopurinol, Lisinopril and Simvastatin. Physical examination revealed tenderness and moderate to severe spasm in the posterolateral cervical area, over the bilateral trapezius and levator scapulae and bilateral posterior occipital area on palpation. Range of motion was restricted 50% on all planes. Right shoulder range of motion was decreased with significant decreased grip strength on the right. The findings were unchanged since the last exam. Treatment plan included medications for pain management. The provider notes the medication maintenance regimen benefit included

reduction of pain, increased activity tolerance and restoration of partial overall functioning. Percocet, Flexeril and Ambien were requested along with follow up and referral to orthopedic surgeon for evaluation and recommendations due to possibility of nonunion of hardware. The request is for Ambien 10 mg # 30.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Ambien10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (DOG) Integrated Treatment/Disability Duration Guidelines, Stress & Mental Illness Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Insomnia Treatment).

Decision rationale: There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long-term use may lead to dependency. Documentation from multiple providers fail to document insomnia or any history related to sleep problems. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. Since the vast majority of progress is missing current medications or any medication planning, it is unclear how long patient is taking this medication. The prescription is not consistent with short-term use or attempts to wean patient off medication. The documentation does not support the use of Ambien. Ambien is not medically appropriate and is not medically necessary.